MDR Tracking Number: M5-04-0682-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-31-03.

The IRO reviewed office visits, physical therapy, injections rendered from 11-19-02 through 9-4-03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On February 12, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

The insurance carrier indicated that disputed bill was a duplicate; however, the original EOB was not submitted. Disputed services denied based upon "D" will be reviewed in accordance with the Commission's *Medical Fee Guidelines.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
11-22-02	99080-73	$20.00	$0.00	V	$15.00	Rule 129.5(d)	Rule 129.5(d) states, "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity

							restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee." 11-22-02 TWCC-73 indicates claimant has not returned to work; therefore, filing of report does not comply with statute. No reimbursement is recommended.
4-10-03	97010	$15.00	$0.00	D	$11.00	CPT Code Descriptor	Report supports reimbursement of $11.00.
8-7-03 8-20-03 8-21-03 8-29-03	97010	$15.00	$0.00	D	$5.55		MAR reimbursement of $5.55 X 4 dates = $22.20.
4-10-03	97250	$44.00	$0.00	D	$43.00		Report supports reimbursement of $43.00.
4-10-03	97035	$26.00	$0.00	D	$22.00		Report supports reimbursement of $22.00.
8-7-03 8-20-03 8-21-03 8-29-03	97035	$26.00	$0.00	D	$15.56		MAR reimbursement of $15.56 X 4 dates = $62.24.
8-29-03	97140	$44.00	$0.00	D	$43.00		MAR reimbursement of $43.00 is recommended.
8-7-03	99213	$60.00	$59.00	F	$59.00	Check ref. 05332187	8-7-03 EOB indicates that $59.00 was paid. No additional reimbursement is recommended.
8-7-03	97265	$50.00	$30.90	F	$30.90		8-7-03 EOB indicates that code 97140 was listed instead of 97265, and $30.90 was paid. No additional reimbursement is recommended.
8-7-03	97014	$18.00	$15.00	F	$15.00	Check ref. 05332187	8-7-03 EOB indicates that $15.00 was paid. No additional reimbursement is recommended.
8-20-03	97140	$44.00	$30.90	F	$30.90	Check ref. 05351332	8-20-03 EOB indicates that $30.90 was paid. No additional reimbursement is recommended.
8-20-03	97110	$40.00	$32.64	F	$32.64		8-20-03 EOB indicates that $32.64 was paid. No additional reimbursement is recommended
8-21-03	99213	$60.00	$59.00	F	$59.00	Check ref. 05354763	8-21-03 EOB indicates that $59.00 was paid. No additional reimbursement is recommended.
8-21-03	97150	$35.00	$21.38	F	$21.38		8-21-03 EOB indicates that $21.38 was paid. No additional reimbursement is recommended.
8-21-03	97014	$18.00	$15.00	F	$15.00		8-21-03 EOB indicates that $15.00 was paid. No additional reimbursement is recommended.

8-29-03	99213	$60.00	$59.00	F	$59.00	Check ref. 05378573	8-29-03 EOB indicates that $59.00 was paid. No additional reimbursement is recommended.
8-29-03	97014	$18.00	$15.00	F	$15.00		8-29-03 EOB indicates that $15.00 was paid. No additional reimbursement is recommended.
9-4-03	99213	$60.00	$59.00	D	$59.00	CPT Code Descriptor	Report supports reimbursement of $59.00.
TOTAL							The requestor is entitled to reimbursement of **$262.44.**

This Decision is hereby issued this 10th day of September 2004

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 11-19-02 through 09-04-03 in this dispute.

This Order is hereby issued this 10th day of September 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

February 11, 2004
Amended February 20, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-04-0682-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Orthopaedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 34-year-old female who developed symptoms of numbness and pain in her right hand and arm while she was working on ___. She consulted her chiropractor, ___, who began to treat her for the next year and a half. ___ suspected that she had carpal tunnel syndrome and tendonitis in multiple areas of her hand. Originally, he saw her in the office on a nearly daily basis and gave her multiple modalities of physical therapy in his office. He also referred her for other types of therapy that included multiple injections for trigger finger and tendonitis of the hand. She received extensive ultrasound treatments and other physical therapy modalities in ___'s office. Finally, after over a year, she had a carpal tunnel release on July 7, 2003 performed by ___. After that procedure, the physical therapy began again at the chiropractor's office.

She has been going regularly there now for approximately one and one half years. The record does not indicate that there has been any real significant change or progress since she began treatment. The patient is still being actively treated by the chiropractor.

DISPUTED SERVICES

Under dispute is the medical necessity of unclassified drug, ultrasound therapy, physical medicine treatment, office visits, physical therapy, therapeutic procedures, injections, ultrasound therapy, group therapy procedures, myofascial release and manual therapy.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ reviewer finds that the treatment that this lady has received ahs been excessive. The record does not indicate that this extensive physical therapy and extensive program

of injections that she received gave her any real significant relief from her symptoms, yet it was continued. The multiple modalities of ultrasound and physical therapy over such a long period of time would not be indicated.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,